TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctor's Hospital at Renaissance

Respondent Name
Old Republic Insurance Co

MFDR Tracking Number
M4-17-3760-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
August 21, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount."

Amount in Dispute: $1,242.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent correctly denied additional payment on this matter as the billed services were either included in other services or the correct amount of reimbursement was issued. Specifically, CPT codes 14040 and 11760 are Medicare status T which makes them not payable due to CPT 26765 being status code J1. CPT 93005 is status code Q1 so it is not allowed since it is not the highest value code. CPT 96374 was denied due to NCCI edit as it is included in CPT 11012. These appear to be the only codes in dispute."

Response Submitted by: White Espey PLLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2017	14040, 11760, 93005, 96374	$1,242.19	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 4915 – The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment
   - 1014 – The attached billing has been re-evaluated at the request of the provider
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking additional reimbursement for the following codes:
   - 14040 - Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
   - 11760 - Repair of nail bed
   - 93005 - Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report
   - 96374 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug

   The insurance carrier denied disputed services with claim adjustment reason codes 4915 – "The charge for the services represented by the revenue code are included/bundled into the total facility payment and do not warrant a separate payment or the payment status indicator determines the service is packaged or excluded from payment" and 97 – "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   28 Texas Administrative Code §134.403 (d) states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

   Review of the Medicare Claims Processing Manual, Chapter 4, Section 10.2.3 at www.cms.gov, states in pertinent part,

   > *Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.*
   >
   > *Claims reporting at least one J1 procedure code will package the following items and services that are not typically packaged under the OPPS:*
   > - *major OPPS procedure codes (status indicators P, S, T, V)*
   >
   > *…When multiple J1 services are reported on the same claim, the single payment is based on the rate associated with the highest ranking J1 service. When certain pairs of J1 services (or in certain cases a J1 service and an add-on code) are reported on the same claim, the claim is eligible for a complexity adjustment, which provides a single payment for the claim based on the rate of the next higher comprehensive APC within the same clinical family.*

The medical bill contained CPT Codes 26765 -F2, 26418 -F2, 14040, 11760 -F2, 11012. While codes 26765 –F2 26418 –F2 and 11012 are not in dispute per Addendum B at www.cms.gov, their assigned status indicator is J1. Based on the applicable Medicare payment policy this status indicator impacts the services in dispute as shown below.

The services in dispute have the following status indicators:

- 14040 – Status Indicator "T." Based on the applicable Medicare payment policy this procedure is packaged therefore, the carrier's denial is supported.
- 11760 – Status Indicator "T." Based on the applicable Medicare payment policy this procedure is packaged therefore, the carrier's denial is supported.
- 93005 – Status Indicator "Q1." This status indicator is defined as (1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator "S," "T," or "V." Based on the definition of this status indicator, the carrier's denial is supported.
- 96374 – Status Indicator "S." Based on the applicable Medicare payment policy this procedure is packaged therefore, the carrier's denial is supported.

The Division has reviewed the applicable Medicare payment policy as defined by 28 Texas Administrative Code §134.403 (d) and found no additional reimbursement is due.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		September 13, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.